BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

# SOCIAL FACTORS INFLUENCING THE ADMISSION OF PATIENTS WITH SENILE OR ARTERIOSCLEROTIC PSYCHOSES

## A Study of Persons Over Sixty Years of Age and Their Need for Admission to the Boston State Hospital

A Thesis

Submitted by

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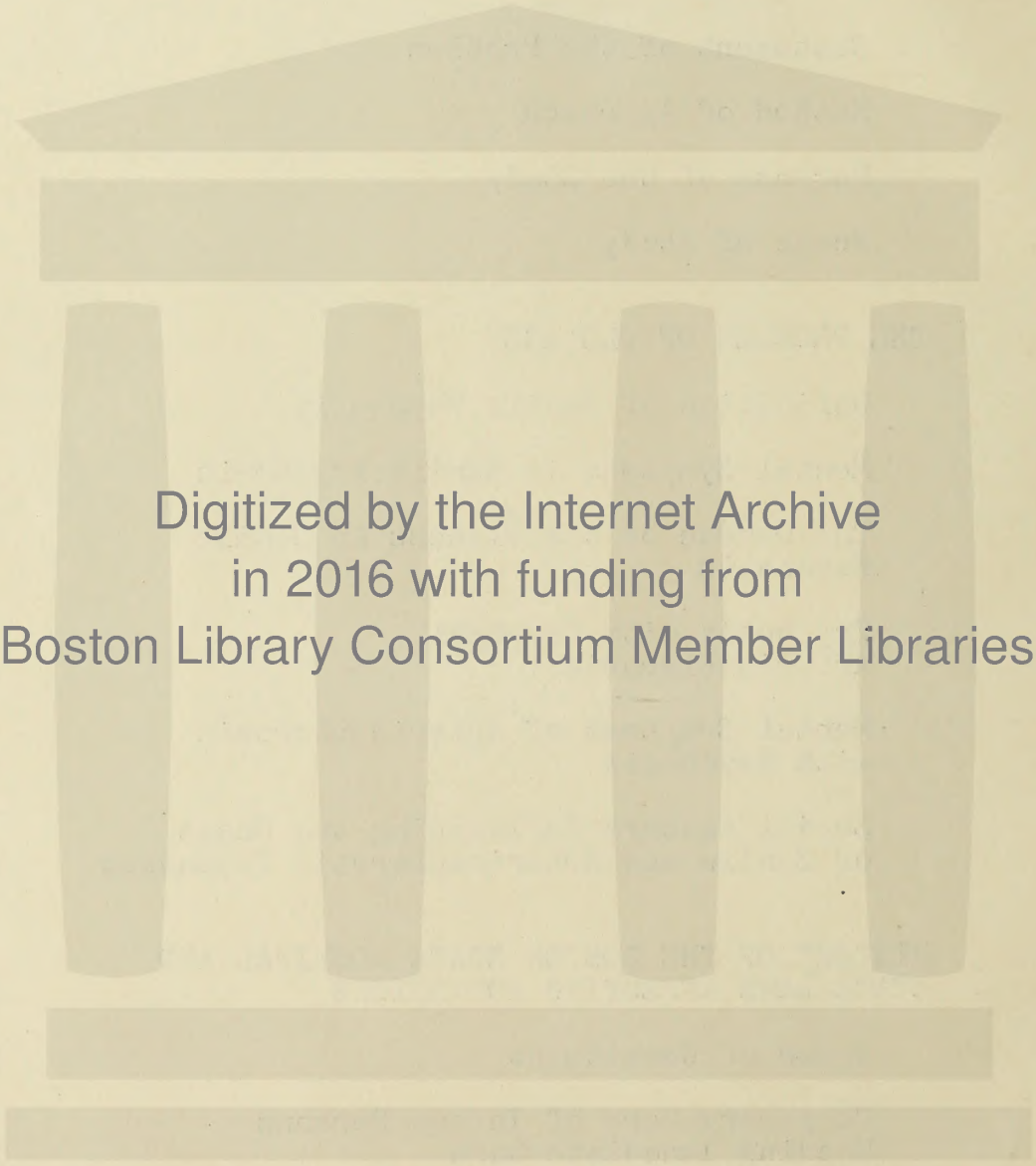

# TABLES

# Chapter I

# INTRODUCTION

## Statement of the Problem

It is the purpose of this thesis to make a study of the social factors influencing senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital.

## Method of Approach

The method used in arriving at a solution to the problem was to make a study of the case records of senile patients with either senile or arteriosclerotic psychosis who were admitted to the Boston State Hospital during a one-month period. The study of these cases was made with a view toward answering the following questions: In what way do the following social factors influence senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?

1. family and marital maladjustments.
2. sickness or other physical ailments.
3. environmental maladjustments.
4. economic maladjustments.

In making the study of the cases, the information for each case was recorded by the use of a schedule as shown in Appendix B. Case material was gathered from medical and social service records at the Boston State Hospital.

Purpose of the Study

It is the purpose of this study to determine against what social factors we can possibly guard our aged. It is essential if we are to maintain a strong and intelligent race that steps be taken to limit the necessity for admissions of the aged to mental institutions. With advancement in science and medicine, people are living longer, thus increasing the percentage of people over sixty years of age. See Table I for the expectation of life from birth and at the age of forty over the period 1900-1942.[1]

Table I

EXPECTATION OF LIFE AT BIRTH AND AT AGE FORTY FOR THE WHITE POPULATION IN THE UNITED STATES FOR SELECTED PERIODS FROM 1900-1942

| Year or Period | Birth | | Age 40 | |
|---|---|---|---|---|
| | Males | Females | Males | Females |
| 1942 | 63.65 | 68.61 | 30.27 | 33.86 |
| 1939-1941 | 62.81 | 67.29 | 30.03 | 33.25 |
| 1930-1939 | 60.62 | 64.52 | 29.57 | 32.24 |
| 1929-1931 | 59.12 | 62.67 | 29.22 | 31.52 |
| 1920-1929 | 57.85 | 60.62 | 29.35 | 30.97 |
| 1919-1921 | 56.34 | 58.53 | 29.86 | 30.94 |
| 1909-1911 | 50.23 | 53.62 | 27.43 | 29.26 |

1 Malford W. Thewlis, M.D., The Care of the Aged, The C. V. Mosby Company, 1946, p. 27.

Table I (continued)

| Year or Period | Birth | | Age 40 | |
|---|---|---|---|---|
| | Males | Females | Males | Females |
| 1901-1910 | 49.32 | 52.54 | 27.55 | 29.28 |
| 1900-1902 | 48.23 | 51.08 | 27.74 | 29.17 |
| Gain: 1900 to 1942 | 15.42 | 17.53 | 2.53 | 4.69 |

Also, along with an increase in the percentage of old people, there is a more rapid increase in admissions to mental institutions of persons in that age bracket as shown in Table II. In Table III, page five, is shown the senile and arteriosclerotic psychoses admissions to Massachusetts mental hospitals compared with admissions for other mental disorders.

Table II[2]

FIRST ADMISSIONS WITH SENILE PSYCHOSES
AND CEREBRAL ARTERIOSCLEROSIS TO THE
NEW YORK CIVIL STATE HOSPITALS, 1920-1942

| Year | Senile | | | Cerebral Arteriosclerosis | | |
|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total |
| 1920-21 | 475 | 808 | 1283 | 626 | 429 | 1055 |
| 1922-23 | 546 | 887 | 1433 | 733 | 471 | 1204 |
| 1924-25 | 569 | 864 | 1433 | 793 | 619 | 1412 |
| 1926-27 | 670 | 859 | 1529 | 1070 | 774 | 1844 |
| 1928-29 | 761 | 983 | 1744 | 1234 | 916 | 2150 |
| 1930-31 | 619 | 929 | 1548 | 1527 | 1139 | 2666 |
| 1932-33 | 759 | 1067 | 1826 | 2029 | 1489 | 3518 |
| 1934-35 | 760 | 1227 | 1987 | 2308 | 1936 | 4244 |
| 1936-37 | 928 | 1375 | 2303 | 2474 | 2052 | 4526 |
| 1938-39 | 1137 | 1558 | 2695 | 2583 | 2264 | 4847 |
| 1940-41 | 1275 | 1756 | 3031 | 2918 | 2490 | 5408 |
| 1942 | 681 | 1017 | 1698 | 1644 | 1518 | 3162 |

2 Horatio M. Pollock, "A Statistical Review of Mental Disorders in Later Life," Mental Disorders in Later Life, Stanford University Press, 1945, p. 12.

Table III[3]

CLINICAL DIAGNOSIS IN FIRST ADMISSIONS
TO MASSACHUSETTS MENTAL HOSPITALS, 1917-1933

| Diagnosis | No. of Admissions | Percentage |
|---|---|---|
| Senile Psychosis | 4 775 | 8.4 |
| Cerebral Arteriosclerotic Psychosis | 7 484 | 13.2 |
| Dementia Praecox | 12 820 | 22.6 |
| Manic Depressive | 6 368 | 11.2 |
| Alcoholic Psychoses | 5 317 | 9.4 |
| General Paresis | 4 003 | 7.1 |
| Involutional Psychoses | 1 433 | 2.6 |
| Psychoses with other Somatic Diseases | 2 297 | 4.1 |
| Undiagnosed Psychoses | 2 482 | 4.3 |
| Paranoia | 1 340 | 2.4 |
| Psychoses with Epilepsy | 1 962 | 3.5 |
| Psychoses with Mental Deficiency | 1 645 | 2.9 |
| Psychoneuroses | 1 524 | 2.7 |
| Psychoses with other Brain and Nervous Diseases | 1 148 | 2.1 |
| Miscellaneous | 1 982 | 3.5 |
| TOTAL | 56 579 | 100.0 |

3 Neil A. Dayton, New Facts on Mental Disorders, Charles C. Thomas, 1940, p. 465.

Scope of Study

This study is based on the cases of the twenty-one patients over sixty years of age who were admitted to the Boston State Hospital during the month of September, 1946, and who were diagnosed as having senile psychosis or cerebral arteriosclerosis with psychosis. The patients' ages ranged from sixty-one to ninety-four and included fourteen men and seven women. Seven men and one woman were diagnosed as having psychosis with cerebral arteriosclerosis and the remaining thirteen as having senile psychosis.

## Chapter II

## THE PROBLEM OF OLD AGE

The problem of the aged has been brought to the public eye more in the past few years because of the large increase of mental disorders among old persons with arteriosclerosis and senile psychosis.

> This whole problem is today more important because more persons now live to be old. The result is that there is a marked increase of the types of mental disorders which occur among old persons, particularly the arteriosclerotic and senile states. This is shown by the statistics of state hospitals, and some superintendents have even expressed the fear that the state hospitals will become more and more a home for the aged rather than an actual hospital for the treatment of mental disorders.[4]

In order that the reader may have a better understanding of the case material to be presented, the first part of this chapter will be devoted to a discussion of the symptoms and meaning of senile psychosis and psychosis with arteriosclerosis. The remaining part of the chapter will be devoted to a discussion of various social factors influencing the onset of senile and arteriosclerotic psychoses.

Senile psychosis and psychosis with cerebral arteriosclerosis are frequently considered together and have not

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4 Karl M. Bowman, Mental Disorders in Later Life, Stanford University Press, 1945, p. 2.

been looked upon as separate disorders until relatively recent times. David Rothschild states:

> . . . the two disorders present different anatomic processes. . . . Senile psychoses are associated with diffuse atrophic changes in the tissues of the nervous system whereas arteriosclerotic psychoses are associated with cerebral vascular alterations and consequent focal damage to the brain.[5]

Definition of Senile Psychosis:

> The senile psychoses are progressive mental disorders due to pathological old age marked by defective mental functioning and notably by impairment of recent memory.[6]

Mental symptoms in Senile Psychosis: The onset of this illness is most always gradual unless it is complicated by arteriosclerotic disease. It is preceded by a normal period of physical and mental "let down" which is attributed to old age. At this time there is noted an exaggeration of earlier personality traits and egocentricities commonly seen in the aged.

There is gradually recognized a failure of efficiency and a general impairment of memory, and patients may move into a psychotic state so slowly that it is difficult to recognize the onset. Sometimes a minor physical condition

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5 David Rothschild, "Senile Psychoses and Psychoses with Cerebral Arteriosclerosis," Mental Disorders in Later Life, Stanford University Press, 1945, p. 233.

6 Edward A. Strecker and Franklin G. Ebaugh, Practical Clinical Psychiatry, Fifth Edition, The Blakiston Company, 1940, p. 17.

or situation may be the cause of the difference between normal aged persons and psychotic persons. Early symptoms of this illness may be errors of judgment, a deterioration of personal habits, loss of moral inhibitions, untidiness, lack of attention, irritable and jealous tendencies. Jealousy sometimes causes persons to threaten or carry out violent actions toward other persons. Symptoms characteristic of this period also are sleeplessness and restlessness. Particularly is this true at night, and frequently patients wander from their homes and are unable to find their way back alone. Some new and abnormal traits may be delusions, hallucinations and paranoid tendencies.

As the psychosis develops, there is intellectual impairment. The memory shows change and patients are unable to recall recent events but are able to remember events of childhood and youth. Senile patients have a tendency to live in the past and reminisce over occurrences in their early life. Fabrications are noted in their conversations. They have poor orientation for time and place and have a loss of self-identity. They also have a lack of comprehension and are in a state of confusion to some degree.

The course of the illness in Senile Psychoses: This disease is gradual with progressive and steady mental and physical decay. The progress of the illness varies from patient to patient, the shortest illness lasting seven

months, the longest, eleven years, and the average, 4.7 years.

Patients, over a period of time, become more feeble and less sure of their footage. Falls are more common and frequent fractures occur because of senile bone changes. General intellectual impairment increases so that patients become more deteriorated, oblivious to their surroundings and have similar characteristics in appearance. Their speech consists of incoherent mumbling noises. They eventually become bedridden and helpless.

Psychosis with Cerebral Arteriosclerosis:

> The differentiation between senile and arteriosclerotic psychoses is always difficult and some times impossible. . . . In general, arteriosclerotic brain disease occurs somewhat earlier in life. Peripheral blood pressure is not a safe index since it is not necessarily high. The authors feel that they have diminished their own margin of diagnostic error by refraining from the diagnosis of arteriosclerotic brain disease unless there is evidence of general (headache, dizziness, fainting attacks, etc.) and more particularly focal (aphasia, paralyses, etc.) brain damage.[7]

Some authors believe that there is an hereditary tendency to arteriosclerotic disease in families of patients with arteriosclerotic psychoses. This disease has also

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7 Edward A. Strecker and Franklin G. Ebaugh, Practical Clinical Psychiatry, Fifth Edition, The Blakiston Company, 1940, p. 178.

developed on the basis of damage to the brain, and in some cases the damage has not differed greatly from that observed in persons who have been normal mentally, so that medical men believe the "presence or absence of a psychosis cannot be attributed to quantitative or qualitative anatomic influences."[8]

> It has been shown that a considerable number of the patients possess inadequate and ill-balanced personalities, as a result of which they are highly vulnerable, breaking down mentally in the face of damage which could readily be overcome by persons of a more robust type. In this sense the personality may be a determining factor in the development of an arteriosclerotic psychosis.[9]

Mental symptoms of Arteriosclerosis with Psychosis: The onset of this illness may be gradual or sudden. Dr. Rothschild stated that an acute onset is noted in more than half of the cases. This takes the form of a sudden attack of confusion and is often associated with gross neurologic disturbances. In this illness, patients show incoherence, loss of contact with their surroundings, and great restlessness. Usually the onset of this illness shows a reduction of physical and mental capacities. Some of the symptoms observed are intellectual failure, loss of efficiency and

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8 David Rothschild, "Senile Psychoses and Psychoses with Cerebral Arteriosclerosis," Mental Disorders in Later Life, Stanford University Press, 1945, p. 267.

9 Ibid.

impairment of memory.

Patients may show a lowering of moral standards, become irritable, quarrelsome and aggressive in behavior; also, there may be such complaints as weakness, fatigue and unpleasant somatic sensations, and a fear of losing physical and mental powers. There are emotional outbreaks of weeping and laughter, ideas of mistreatment and jealousy. Persecutory ideas are often observed, but paranoid tendencies are rarely seen. Their judgment is impaired but there is some degree of insight.

The course of this illness varies from case to case. Some of the acute confused or delirious conditions which may initiate the psychosis last for weeks or months. Half of the cases die and the other half improve, leaving the patients with some mental impairment. The chronic illness sometimes lasts as long as sixteen years. The average duration for patients treated in hospitals for mental diseases is 3.4 years.

The arteriosclerotic patients do not show the same physical and mental decay as the senile patients; but they are frequently bedridden and helpless because of cardiac condition and neurological disturbances.

Social factors influencing the onset of Senile and Arteriosclerotic Psychoses: In order to gain more understanding of aged persons, a discussion of their problems and

adjustments in relation to health, environment, economic condition will be given.

Human bodies beyond the sixties begin to slow down before they show symptoms of wearing out. The physical decline is shown in motor performance, perception and learning, sensory acuity, muscular and secretory responses and neural coordinations. There tends to be a muscular and bone atrophy which contributes to the characteristic appearance and stature of the aged. The skin changes and becomes more creased and wrinkled.

The biological factors in senile men patients which cause the most difficulty in adjustment are: general reduction of strength, endurance, skill and sexual prowess. In women, there is the beginning of infertility and a continuous loss of attractiveness which tends to cause pessimistic neglect of their personal appearance. A reduction of strength and endurance is very gradual so that one may become aware of it suddenly after an illness, an injury, continual fatigue, or after some unsuccessful competition with a younger person. The maladaptation to this reality situation may result in aging persons giving up too easily with complaints of fatigue, weakness, incapacity, or they may refuse to recognize or accept their physical condition and try to show others as well as themselves that they are as able as they ever were to do a given task. This is revealed in the form

of rationalization, trying to impress others with their competence.

Patients who have been strong-minded dominant persons in the family group will not give up their positions but will become more tenacious in their will to dominate as a means of compensation for their physical and mental inadequacies. During this period of overcompensation, there is frequently developing a state of tense anxiety, patients grow restless and irritable, have difficulty sleeping at night and suffer loss of appetite.

Patients' loss of vision and hearing ability plays significant role in their behavior and general attitude. It takes away a great source of pleasure from them and isolates them from society so that they cannot participate actively in their social group. This affects individuals' personalities. They are now unable to keep up with sufficient interchange through satisfactory communication with people and there develops feelings of isolation, loneliness, and uselessness. Particularly is this true when they are eliminated from regular conversations of others. This develops misunderstandings and misinterpretations which take a great deal of time and patience to rectify, particularly in the case of half blind and half deaf patients. If these patients' suspicions and ideas are not corrected, they will increase as time goes on and become distorted, causing anxieties, fears

and discouragement.

Throughout this discussion there is shown the relationship and dependency of psychological factors upon the physiological condition to some degree.

Aged parents and their adult children in some families live together and there exist strong emotional tensions which are not conducive to good health and happy living conditions. As a result, the adult children who do not have close family solidarity seek an escape method to release themselves of the responsibility of their parents' care.

The reason why the aged parents are not able to live with their children harmoniously may be because of several factors. Older people slow up mentally and physically, have habits and ideas that have been well developed in the past in a world unlike their children's and as time goes on these ideas have become fixed so that they follow set routines and resist changes and become irritable when forced into unfamiliar patterns. Their personal habits change; although once tidy and clean, they show slovenliness in dress and manners. They become suspicious of people, demanding and domineering in the home. This attitude is sometimes attributed to an overcompensation for their inadequacy and craving to be loved.

The number of aged separated from their families is more common in the urban area than in the rural area. It has been

stated by one author that, "urbanization is erroneously assigned as one cause for the increase in hospital admissions."[10] Urbanization has developed many separate households for relatives as a generation ago the family would have been larger and more closely united. Today, the household is smaller in size and in many cases small conjested apartments have replaced separate homes so that there would actually be no more room for an additional person in the home. In cases where aged parents have never lived with their children in the urban area, it is easier for the children to transfer the responsibility, which is usually done by placing the parents in an institution, whereas, if the parents had been living with them, they would be more reluctant to put them out when they became infirm and in need of care.

Decades ago, when this country was largely rural, the aged had an honored place in the family household. The home was so situated that it could always take care of another person. Food was adequate and there was light work which the older person could do so that the grandparents had a place in the home and were made welcome. With the movement of families toward the urban area, a change in the country's attitude toward the aged has been brought about.

The aged may react to their declining abilities by

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10 Nelson A. Johnson, "The Growing Problems of Old Age Psychosis," Mental Hygiene, July, 1946, p. 443.

withdrawing from their struggle and so restrict their activities and interests. After they are unsuccessful in their attempts for domination, aged persons seek withdrawal from the environment and develop more interest in their own body machinery.

Aged persons have increasing difficulty adjusting to their environment because they have their own habitual reactions to change. They may have conflict, frustrations and feelings of neglect. There may be modes of evasion, aggression, or they may have dominant needs, wishes, fantasies, anxieties and fears which alter their attitude in relation to their surroundings.

Aged persons are frequently called upon to make important adjustments in their living conditions, their places in society, their occupations. These serve as a threat to their security. Also, through the years, older persons become more conservative and intolerant to social changes. They have greater feelings of reliance upon fixed routines and habitual attitudes. They are incapable of learning, retaining attitudes and using new ones without a great deal of effort.

> He cannot any longer escape the increasing pressures of his environment by a further retreat, because there is nowhere left for him to go. He has the unhappy choice then of either fighting back or refusing to meet the situation. If he chooses the former, he may resort to direct or substitute aggressions. These are unlikely to

succeed because of his lost prestige and independence.[11]

Adverse environmental situations are very common in old age patients in cases of foreign-born parents who come to this country and have a new environment of laws and social customs to learn and accept.

Throughout the aged person's life, he is faced with problems of frustrations, and conflicts in his environment. The patient's inability to adjust to these problems causes emotional insecurities which may contribute to psychosis.

The change which older persons dread most is their retirement and loss of independence. This threat of social and economic dependence upon relatives or society is feared more than death by aged persons. Many of the patients have lived on marginal incomes and have not been able to accumulate enough reserves for later years. Some relatives are interested in the patients, but they have limited resources; some have helped the patients over an extended period of time but do not wish to continue this help. There are also some families who will not make the sacrifice for their relatives; and there are those cases where the elderly patients have never married or are widowed and have no children or close relatives. Those elderly persons without family

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11 Norman Cameron, "Neuroses of Later Maturity," Mental Disorders in Later Life, Stanford University Press, 1945, p. 166.

ties may live in lodgings on meager finances, eating improperly and becoming malnourished. Some eat in restaurants and go out for their meals in all kinds of weather. They climb many stairs to go back and forth to their rooms, as cheaper rooms are not on the first floor. Many of the aged persons come to feel the rooming house they live in is their home and the landlord their closest friend.

As a consequence of dependence, aged persons have to accept compromises and sometimes change their own established patterns of living. They are lifted out of their own familiar surroundings, neighborhoods and acquaintances. Many aged persons cannot adapt themselves to this change. Reactions to this uprooting bring about tense anxiety on the part of the patients which may develop pathological disturbances. As a result of their loss of gratification, they develop symptoms of fatigue and incompetence or they may take refuge in fantasy and reminiscence.

Besides the loss of familiar objects, persons and routines upon which they are greatly dependent, there is the loss of social significance which comes in old age. Some of the anxiety that develops with economic dependence is due to the loss of prestige. The aged do not wish merely to sit on the sidelines unnoticed and admire the leadership of a person they can remember in rompers. As a result, distressing conflicts and hostilities develop to which aged persons are unable to

adjust. The personality trends that enabled some older persons to dominate successfully and gain prestige in early and middle maturity may now stand in the way of their accepting the altered conditions of later maturity. Lost authority and influence and suddenly lowered prestige in persons who for a long time have taken these things for granted are known to give rise to substitute neurotic aggressions, such as hypochondriac complaints and attitudes of martyrdom. This is a stubborn refusal to acknowledge their own changed status when it is already an established fact.

Retirement from work has an important psychological effect on persons when it comes too early or too suddenly. Individuals who have been active all their lives and are suddenly thrown into inactivity find it difficult to adjust themselves as they are lost in endless spare time. They lose their external routine of habits and personal identity. It is this experience of not being wanted or needed, of being deprived of the incentive and the opportunity to carry on their accustomed work that brings on a feeling of restlessness, chronic fatigue, dejection and depression with great feelings of self-depreciation.

Oscar Kaplan and Harold E. Jones state:

> The economic causes of mental disease in senescence can be dealt with in one of two ways: Either we must educate the masses of our people to expect and to resign themselves to a much lowered standard of living during the closing

> years of life, or we must arrange in some way for the continuation of earlier standards even after retirement.[12]

Studies made by Oscar J. Kaplan from patients in State Hospitals in California and New York between 1935 and 1939 showed that a majority of them with senile psychosis and cerebral arteriosclerosis had only a grade school education although there was a higher percentage of patients with a diagnosis of involutional melancholia who had a high school or college education. Kaplan attributed this to the fact that patients with involutional melancholia are younger than patients with senile psychosis and cerebral arteriosclerosis and therefore have had more opportunity to take advantage of the rising level of education in this country. Most of the patients studied from this group came from a marginal or dependent economic status. Persons with a college education are more apt to be economically independent than those persons who have had only a grade school education. There is a possibility that higher educational opportunities may have some relationship to the decline of mental powers.

> In view of the relationship between educational status, economic status, and intelligence, it is quite possible that the slower decline in the educationally more privileged groups may reflect better physical conditions, better medical care, and a superior biological selection . . . .

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12 Harold E. Jones and Oscar J. Kaplan, "Psychological Aspects of Mental Disorders in Later Life," Mental Disorders in Later Life, Stanford University Press, 1945, p. 109.

> Although education tends to increase adaptability, and hence to prepare the individual for the psychological changes that accompany the aging process, it does not constitute a guaranty against psychotic symptoms attendant upon severe or extensive brain destruction; a college degree will not prevent paresis, arteriosclerotic changes, or other conditions essentially organic in character.[13]

Table IV, page twenty-three, shows Kaplan's findings on the relationship of education to psychosis in the state of California.

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13 Harold E. Jones and Oscar J. Kaplan, "Psychological Aspects of Mental Disorders in Later Life," Mental Disorders in Later Life, Stanford University Press, 1945, pp. 91-92.

Table IV[14]

EDUCATIONAL CLASSIFICATION (PERCENTAGES) OF SENILE AND CEREBRAL ARTERIOSCLEROTIC PSYCHOSES IN CALIFORNIA STATE HOSPITALS, 1935-1939 AND OF CALIFORNIA GENERAL POPULATION SIXTY AND OVER IN 1940

| Education | Senile | Cerebral Arteriosclerosis | General Population 60 and Over |
|---|---|---|---|
| Total N | 945 | 2644 | 854 996 |
| College | 3.8 | 4.9 | 10.5 |
| High School | 9.6 | 10.3 | 24.6 |
| Grade School | 62.5 | 63.1 | 58.8 |
| Reading and/or Writing | 12.5 | 11.0 | .... |
| Illiterate | 6.3 | 6.5 | 4.5 |
| Unknown | 5.2 | 4.2 | 1.6 |

14 Harold E. Jones and Oscar J. Kaplan, "Psychological Aspects of Mental Disorders in Later Life," Mental Disorders in Later Life, Stanford University Press, 1945, p. 92.

## Chapter III

## HISTORY OF THE BOSTON STATE HOSPITAL AND THE STATE LAWS AFFECTING ADMISSIONS

The Boston State Hospital was founded by the city in 1838 under the name of the Boston Lunatic Hospital at South Boston. This was the third hospital for the insane in the state. For forty years the hospital remained in the same condition, being overcrowded and in need of repair.

The first building that the city of Boston had erected for its insane in fifty-four years was in 1893 on Austin Farm, Roxbury. The following year, the other buildings at Austin Farm were occupied. In 1895 the hospital in South Boston was abandoned and the patients were transferred to the new buildings at Pierce Farm. The hospital was then established in two divisions, about a half a mile apart, and accommodated about five hundred patients.

In 1897 the name of the hospital was changed to the Boston Insane Hospital. In the beginning, the departments were made independent with separate superintendents. In 1898 these two departments were consolidated under one superintendent and the names were changed from the Austin Farm to the Department for Women and from Pierce Farm to the Department for Men.

By an act of 1908, Chapter 613, all of Boston's insane came under the state's care. All persons who had been

previously cared for by the city of Boston were now under the control, care and treatment of the state. The Boston Insane Hospital then became the Boston State Hospital.

The psychopathic department of the Boston State Hospital, known today as the Boston Psychopathic Hospital, was built in 1910 and opened for patients in the summer of 1912. This department of the Boston State Hospital was set up to care for the acute and curable insane. In 1930 it became a separate institution.

The Boston State Hospital is one of the few in the country to have a research department. The electric shock treatment began in February, 1941; it has largely replaced insulin shock and metrazol shock. Within the past few years they have performed lobottomy operations.

Patients are largely of Irish, Jewish or Italian descent, which is due to the fact that the population served by the hospital in the Boston area is largely of the same extraction.

In 1913, the Social Service Department was set up at the Boston State Hospital because it was felt to be an integral part of the hospital's organization. It was also thought that it would bring about more lasting benefit to the patients and the community. The purpose of this department from the beginning has been to help the patients with their varied needs, such as placing improved or recovered patients out on

trial visits. This requires making the most suitable placements possible. The patients are placed in homes, industry or some other environment adapted to their needs. Follow-up work is done on the patients after they have been placed in the community by way of supervisory visits by the social worker. In this way the social worker can help the patients adjust better to any emotional and practical problems which confront them. The Boston State Hospital is one of the few state hospitals to provide family care for its patients. This is the duty of the Social Service Department.

One of the functions of the social worker has been to gain a better understanding of the social factors that influence the patient's hospitalization. She obtains this information from a combination of sources, preferably the patient, the patient's family and relatives, and community resources. Through these means, the social worker is able to give the medical staff a broader picture of the patient's earlier life and facts just prior to his hospitalization. These may have a direct bearing on his present condition and also may help the medical staff and social worker in their focus of treatment.

The social worker has an important role in interpreting the patient's condition to the relatives. Sometimes the relatives have a deep fear of mental hospitals which may come from inadequate knowledge of the mental hospital or because of

the social stigma. The social worker strives to alleviate the anxiety of relatives so that they are better able to accept the patient's mental illness and also better prepared and qualified to help the patient with his adjustment when he returns to his home and community.

The following two sections of the Massachusetts laws are the sections under which the majority of the patients are admitted to the Boston State Hospital:

> Section 51: Order of Commitment - No person shall be committed to any institution for the insane designated under or described in section, except the Walter E. Fernald State School, the Belchertown State School and the Wrentham State School, unless there has been filed with the judge a certificate in accordance with section 53 of the insanity of such person by two properly qualified physicians nor without an order therefor, signed by a judge named in the preceding section stating that he finds that the person committed is insane and is a proper subject for treatment in a hospital for the insane, and either that he has been an inhabitant of the commonwealth for the six months immediately preceding such findings or that provision satisfactory to the department has been made for his maintenance or that by reason of insanity he would be dangerous if at large. The order of commitment shall also authorize the custody of the insane person either at the institution to which he shall first be committed or at some other institution to which he may be transferred. Said judge shall see and examine the alleged insane person, or state in his final order the reason why it was not considered necessary or advisable to do so. The hearing, unless a jury is summoned, shall be at such place as the judge shall appoint. In all cases he shall certify in what place the insane person resided or was at the time of his commitment; or, if the commitment is ordered by a court under section 100 or 101, the court shall certify in what place the insane person resided or was at the time of the arrest upon the

charge for which he was held to answer before such court. Such certificate shall, for the purposes of the preceding section, be conclusive evidence of the residence of the person committed.[15]

Section 79: Temporary Care of Insane Persons Needing Immediate Care - The superintendent or manager of any institution for the insane, in the case of the Gardner state colony when so authorized by the department, may, when requested by a physician, member of the board of health, sheriff, deputy sheriff, member of the state police, selectman, police officer of a town or by an agent of the institutions department of Boston, receive and care for in such institution as a patient, for a period not exceeding ten days, any person needing immediate care and treatment because of mental derangement other than delirium tremens or drunkenness. Such request for admission of a patient shall be put in writing and be filed at the institution at the time of his reception, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the department, giving such information as it deems appropriate. Any such patient deemed by the superintendent or manager not suitable for such care shall, upon the request of the superintendent, or manager, be removed forthwith from the institution by the person requesting his reception, and if he is not so removed, such person shall be liable to the commonwealth or to the person maintaining the private institution as the case may be, for all reasonable expenses incurred under this section on account of the patient, which may be recovered, in contract by the state treasurer or by such person, as the case may be. The superintendent or manager shall cause every such patient either to be examined by two physicians qualified as provided in section 53, who shall cause application to be made for his admission or commitment to such institution, or to be removed therefrom before the expiration of said period of ten days, unless he signs a request to remain therein under section 86. Reasonable expenses incurred for the examination of the patient and his transportation to the institution shall be allowed,

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15 Massachusetts G. L., Ch. 123, s. 51.

certified and paid as provided by section 74.[16]

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16 Massachusetts G. L., Ch. 123, s. 79.

# Chapter IV

## STUDY OF CASES

It is the purpose of the writer, in the study of the cases, to look at them with a view toward answering the following questions: In what way do the following social factors influence senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?

1. family and marital maladjustments.
2. sickness or other physical ailments.
3. environmental maladjustments.
4. economic maladjustments.

The eleven cases with the most complete information were selected for discussion from a group of patients admitted to the Boston State Hospital during the month of September, 1946. The group consisted of twenty-one patients over sixty years of age and whose diagnosis was one of senile or arteriosclerotic psychosis.

See Table V, page thirty-one, for a classification of patients by diagnosis; Table VI, page thirty-two, for a classification according to the country of their birth; and Table VII, page thirty-two, for a classification according to their formal education.

Table V

PATIENTS ADMITTED TO THE BOSTON STATE HOSPITAL
DURING THE MONTH OF SEPTEMBER, 1946

| Classification | No. | Percentage Of Total | Percentage Over 60 Years |
|---|---|---|---|
| Total Patients Admitted | 88 | | |
| Patients Over 60 Years | 35 | 39.8 | |
| Patients Over 60 Years with Senile Psychosis or Psychosis with Arteriosclerosis | 21 | 23.8 | 60 |
| Patients Over 60 Years with Other Mental Illnesses | 14 | 16.0 | 40 |

Table VI

BIRTH PLACES OF THE PATIENTS UNDER STUDY

| Places of Birth | No. of Patients |
|---|---|
| Canada | 5 |
| United States | 10 |
| Germany | 1 |
| Ireland | 2 |
| Italy | 1 |
| Russia | 2 |
| TOTAL | 21 |

Table VII

THE FORMAL EDUCATION OF THE 21 PATIENTS OVER 60 YEARS OF AGE AND WITH SENILE OR ARTERIOSCLEROTIC PSYCHOSES

| Education | No. of Patients |
|---|---|
| None | 2 |
| Very Little | 3 |
| Grammar School | 4 |
| High School | 2 |
| Unknown | 10 |
| TOTAL | 21 |

## Family and Marital Maladjustments

In the following cases, family and marital maladjustments play an important role in the patients' lives. These cases are given in an attempt to answer the question, "How do family and marital conditions influence senile or arterio-sclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?"

Case I:

Mrs. J., a widow, is seventy-four years old and was admitted to the Boston State Hospital on September 4, 1946. She was diagnosed as having senile psychosis of the depressed and agitated types. The patient had been transferred under Section 51 commitment papers from the Boston City Hospital where she had been admitted for multiple cerebral thromboses. The physician's certificate from the Boston City Hospital stated that she could not be managed outside a hospital. Upon admission she exhibited emotional liability, poor orientation, confusion and gross memory defects. Physical examination revealed a blood pressure of 180/110, a questionable cardia enlargement, eye changes and tuberculosis.

The patient was poorly oriented and presented vague paranoid trends. She said, "I can't bear to look at you." Her attitude and manner were ones of continual complaining and non-cooperation to the nurses in her care. She was not careful of her own habits and her toilet care. In her stream of mental activity there was no evidence of pressure of thought or retardation. She showed no physical tension outwardly and had no gesturing throughout her conversation. In her interview, she showed practically no emotional display, but had a frowning look and a complaining manner.

Mrs. J. was born in Maine, in 1872. She was one of five children, having two brothers and two sisters. She always leaned toward the

younger brother, who was the informant in this case. Marital relations between her mother and father were always strained. The father was a chronic alcoholic and died of drowning. The mother died of cancer of the rectum. During the mother's menopause period, she had epileptic seizures. The paternal grandfather was said to be an evil, jealous person and very religious. The paternal grandmother died of a shock. One paternal aunt was feebleminded following scarlet fever, another paternal aunt died of tuberculosis and a third of heart trouble and spinal meningitis. The latter was supposed to have been insane just prior to her death. A paternal uncle was an alcoholic. All of the paternal relatives were said to have been extremely nervous.

The patient did well with the little schooling which she had. Her ambition was to become a Registered Nurse. She was a conscientious church goer and had a marked fear of darkness and alcohol. Her most obvious characteristic was that of lip biting which she did all her life. Her father's fondness for liquor caused considerable worry to the patient.

Her husband was of English descent and a machinist by trade. It is recorded that Mrs. J. never accepted her husband's relatives which resulted in constant strife between them. The last child was a son to whom the mother was very devoted, placing him above her husband. The husband became despondent and during a period of depression he committed suicide.

During the patient's later life her only interests were in her family, practical nursing and church affairs. She showed a marked interest in illnesses of others.

Her illness began at the death of her son who died at the Metropolitan State Hospital in 1942. He had been in various mental institutions for a period of twenty years. His death was caused by rheumatic heart disease and cardiac decompensation.

This case is a picture of a person growing old and having continual difficult family situations. She is struggling to adjust to personal problems and is trying to compensate for her difficulties by developing strong suspicions toward other people. In this case, there are several conditions contributing to the final mental breakdown of the patient; such as, mental illnesses throughout the family, economic maladjustments, difficult situations in her family and married life.

It must be assumed that general bodily disorders accompanied the worry, tension and tribulations. It is generally true that worries and continuous tension have a weakening effect on the body. Also, it is know that senile psychosis does not appear suddenly, but comes on gradually although it may not be apparent for some time.

The patient's family life was badly maladjusted resulting in her being left without any close relatives or friends. The poor family background, the mental and physical illnesses of her relatives are reflected in this patient's mental condition. In her home life, one difficulty followed another. She lived in the midst of tragedy, each succeeding one probably bringing more deterioration until finally her equilibrium, which before she had been able to maintain, was lost.

Case II:

Mrs. W., age sixty-nine, was admitted to the Boston State Hospital on September 19, 1946. Her case was diagnosed as senile psychosis. The patient was brought from home by her niece and son. Upon admission she had hypertension, ankle edema, numerous bruises and a systolic heart murmur. The patient was quiet and cooperative. She claimed to be afraid her niece would harm her. Information from the temporary care papers stated that following an attack of phlebitis, the patient became restless and developed delusional ideas, stating that, "she had told the doctors she was a sinful woman and that her husband wished to bury her." The patient believed she was in a reformatory, stating that she hadn't been able to get along with her husband or niece. Mental examination revealed this woman to be depressed, retarded and slow in her responses and confused; but she was oriented as to time and gave her correct age. She entertained paranoid ideas toward her niece who wishes, according to the patient, to poison her. She also believed her husband might kill her. The patient admitted freely that she had suicidal intention prior to her hospitalization.

The patient was the youngest of seven children born to parents in Nova Scotia, Canada. Her mother was of English descent and her father of Welsh descent. He was a seaman. The patient had a happy religious family life with her parents and siblings. Her father died at sixty years of age from cancer of the throat; her mother died of natural causes in her old age.

The patient started school at six years of age and was sixteen when she was graduated from high school. She enjoyed outdoor sports, mainly ice skating and swimming. Later in life, she enjoyed whist, bridge and the theater.

The patient was in the best of health throughout her childhood. She had children's diseases but suffered no ill effects.

The patient and her husband recently celebrated their golden wedding anniversary. They knew each other nine years before they were married.

He has been a railroader most of his life and has worked since the age of twelve. He has been a steady and hard worker for his family. The husband was very patient and understanding during his wife's sickness and has done all that he could to make a good home for his wife and eight children. Two of the children died at an early age, three daughters and a son are now living in Halifax, Nova Scotia, and the three sons are living in Massachusetts. One is unmarried and has been living with his parents. The sons are self-supporting and the daughters are married.

The patient has always had a tendency to worry, particularly about her children. One of her sons had an accident on the railroad at the age of eighteen in which he lost his legs. His mother's hair "turned gray overnight" when she first knew of his amputation. A daughter, who is the closest to her mother, had rheumatism at the age of fifteen and was unable to walk for six months; she had several operations. Another son, Thomas, had a nervous breakdown brought on by a drowning accident in which he escaped and his chum was drowned. He died when he was twenty-four. His death was due to a heart and kidney ailment. Another daughter died at the age of five from an injury to the spinal cord.

The patient in the past few years has worried about her sons. One was in the service and one drank heavily and carried on a friendship with a girl who she felt was undesirable for her son. The patient's greatest worry was the fear that she was developing cancer of the throat. She had harbored this fear within herself for many years.

About seven years ago, she had a bad injury to her left hand and was treated at the Boston City Hospital. She also had several bad falls but did not wish any treatment. During one of her illnesses she got out of bed and being so weak and dizzy she fell, receiving a bad blow on her head. The patient had an attack of phlebitis and a heart attack.

After these illnesses, the patient started to have nightmares. This was about the middle of

July, 1946. Later she gradually began to imagine things. During the day, the false ideas she had were that people were in the house and waiting for an opportunity to injure her or to operate on her. She feared her husband was going to do something terrible to her.

Finally, she became suspicious of food and drink that was given her because she felt it was poisoned. The patient developed the idea that she was unworthy of her family, their love, and of God. After she recuperated enough from her illnesses and was able to get up, she tried to get away from these ideas by attempting to do harm to herself. She did not go through with it because of her strong religious belief that in doing so she could never go to heaven. This condition developed so that the family physician recommended hospitalization in order to get treatment and protection in the event of her suicidal attempts.

This case is a picture of a person who was brought up in a happy home atmosphere, enjoyed good health, and was apparently fairly bright, having been graduated from high school at the age of sixteen. The record showed that she had always worried about her children. Her sorrow when she learned her eighteen-year old son had his legs amputated in a railroad accident, the illness of her daughter, another son's breakdown following the drowning of his chum and the third son the victim of alcoholism caused so much worry and concern that one may assume that these were contributing factors in her final breakdown.

In addition to these tragedies to her family, the death of her father, caused by cancer of the throat, left a very marked impression on the patient because after senility had

set in, she was convinced that she was dying of cancer of the throat. The fear of cancer through the years preyed on her mind becoming increasingly worse as she grew older.

As in Case I, difficult family situations had taken place and the patient, in trying to struggle against them, had developed suspicions about her family and later toward food and water. These ideas had led to thoughts of suicide which might possibly happen at a later stage.

The relatives felt unable to care for the patient at home, and it was advised by the family physician to have the patient removed to the hospital where she would receive closer supervision and care.

Case III:

Mr. L., age seventy-five, was admitted to the Boston State Hospital on September 4, 1946. His diagnosis was that of senile psychosis, simple deterioration type. The patient was brought from home by his son and daughter and admitted under Section 79. The son and daughter stated that at home the patient would often get lost and was in need of mental care.

Four days after admittance to the hospital, the patient thought that he had been there for two weeks. He stated that his memory was gone; he did not know the day or the month and stated the year was 1944. Upon admission to the hospital he was quiet and cooperative, but very tense and suspicious. He spoke proudly of the achievements of his children and his own fine business record, but said that at present he felt down-hearted and frightened. He stated, "My memory goes away so fast. In an hour I'll forget where I am. It's a shame." There was no evidence of hallucinations or delusions.

Upon physical examination it was revealed that he had a loud harsh precardial systolic murmur.

The patient was born in Russia of Russian-Hebrew parents. He was the oldest of three children, having a brother and sister. The patient had little use for his father who was very domineering and indifferent. At the age of nine, the patient, along with his brother and sister, was brought to this country by the mother.

Little is known about the patient's early life other than that he had little schooling and supported his mother who died about thirty-five years ago. The brother and sister were both deceased. The patient and his siblings had little to do with each other. The patient in recent years forgot that the brother and sister even existed. The brother had a similar mental illness before his death.

The patient married and had three children. His married life was never a happy one for his wife was sickly and died of a tumor at the age of thirty-one. There had never been any real affection for the patient by his children. He had always been more influenced by financial considerations, even to the extent of depriving himself unnecessarily. He had preferred to live by himself and suspected others of taking advantage of him.

The record indicated that the patient did not have any previous mental illness but had a tendency to worry. His interests in life were very limited. He kept by himself most of the time and had always been very close and secretive about his personal and financial affairs. Even his own children were never taken into his confidence.

Four years ago, the patient was operated on at the Boston City Hospital for a strangulated hernia. Other than that and complaints about "rheumatism in his joints" the patient had been in fair health.

A decided change came in the patient about four years ago. His memory began to fail him and he became steadily worse. He had always used wine in moderation but in recent months he had been

drinking to excess, sufficient to make him unsteady on his feet. When on the street alone, he had to have assistance from strangers. Both his sons and daughter were working and unable to take care of him. He was, therefore, taken to the hospital because of his inability to take care of himself and as a protection against harm.

This case shows a picture of family disorganization from the patient's childhood through manhood. This was shown when the patient, the eldest sibling, left Russia at the age of nine with his mother, brother and sister. The patient was hostile toward his father and viewed him as a domineering, indifferent person. He felt overidentified with his mother and took over a paternal role. Later in his life he began to assume mannerisms and habits and personality traits of his father which may indicate guilt feelings for his attitudes toward his father.

The patient expressed an unhappy marital life because of his wife's illness and death at an early age. He displayed feelings of indifference and rejection toward his children. He always preferred to live by himself and was absorbed with financial considerations. This may have developed because of his difficulty in having adequate financial resources as a child. It became an obsession with him so that he deprived himself unnecessarily.

After the patient was operated on four years ago at the Boston City Hospital, he started to drink to excess, sufficient to make him unsteady on his feet. When on the streets

alone, he had to have help from strangers. His memory began to fail him and he became steadily worse.

Here is a picture of a man who has been going through a transition of physical changes in his advanced years. As was brought out in Chapter II, a patient's body beyond the age of sixty begins to slow down and wear out, and there is difficulty adjusting to this condition. The reduction of strength and endurance is so gradual that they may become aware of it suddenly after an illness, injury, continual fatigue or an operation such as this patient had. The maladaptation to this reality situation may result in aging persons giving up too easily or they may utilize alcohol as a means to handle a situation they do not wish to accept, which may have been the reason Mr. L. began to drink to excess.

The sons and daughter were working and unable to take care of the patient. He was taken to the Boston State Hospital because of his inability to take care of himself.

## The Relationship of Physical Condition to Senile and Arteriosclerotic Psychoses

Of the twenty-one cases studied, seventeen of the patients had a physical sickness prior to the need for hospitalization in a mental institution. All of the patients studied had ailments of some type. In Table VIII, page forty-three, are listed the sicknesses or ailments that

occurred more than once in the fourteen men and seven women whose cases were studied.

Table VIII

OCCURRENCES OF SICKNESS AND AILMENTS IN THE STUDY OF FOURTEEN MALE AND SEVEN FEMALE PATIENTS WITH SENILE AND ARTERIOSCLEROTIC PSYCHOSES

| Sickness or Ailment | Male | Female | Total |
|---|---|---|---|
| Cerebral Arteriosclerosis | 7 | 1 | 8 |
| Pneumonia | 1 | 1 | 2 |
| Partial Paralysis | 5 | 0 | 5 |
| Absent Reflexes | 5 | 0 | 5 |
| Fixed Pupils | 4 | 1 | 5 |
| Aphasia | 2 | 1 | 3 |
| Deafness | 2 | 1 | 3 |
| Hernia | 3 | 0 | 3 |
| Systolic Murmurs | 3 | 0 | 3 |
| Inflammations | 0 | 3 | 3 |

It is the purpose of this section of the chapter to attempt to answer the question, "How does sickness influence senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?" The following three cases came within this classification.

Case IV:

Mr. M. was admitted to the Boston State Hospital on September 17, 1946, and was diagnosed as having cerebral arteriosclerosis with psychosis. At the time of admittance the patient had a right-sided hemiplegia and was unable to talk. Physical examination at the hospital showed a blood pressure of 140/94 and a weak irregular heart.

The patient had been brought to the hospital from a rest home in which he had been bedridden. The manager of the rest home had requested that the Boston State Hospital take the patient because he had become very noisy, yelling loudly at night.

No information could be obtained from this feeble old man because when asked a question, he would reply, "I . . . I . . ." but could not continue conversation. Mr. M. had no close relatives but the following information was obtained from the Old Age Assistance Bureau.

The patient was seventy-seven years old, born in 1869 in Kansas and had married in California in 1894. His wife died in 1915. The patient lived by himself in a furnished room in Boston from 1929 to 1936.

He had once been a prosperous business man with a good income. His last occupation had been the manufacture and sale of novelties. In 1936, after he became a recipient of Old Age Assistance, he moved to a rest home in Dorchester. On March 20, 1942, he suffered a severe paralytic stroke and had to be removed from the rest home to the Peter Bent Brigham Hospital. When he was able to leave the hospital, arrangements were made for his care at another rest home. He has been a bed patient since 1942. Since the stroke, he has been untidy and confused. This condition has increased to such an extent that he was transferred to the Boston State Hospital.

This case is a good example of physical deterioration leading to complete physical and mental breakdown. It is very

characteristic of senile persons to suffer similar illnesses, such as, heart trouble and arteriosclerosis accompanied by paralysis, aphasia and deafness.

In this case, the patient had cerebral arteriosclerosis. Simple deterioration had been taking place for some time and finally resulted in a paralytic stroke causing the patient to be bedridden and to lose his power of speech with increased mental deterioration. At the time this physical breakdown occurred, the patient, who previously had been able to maintain his equilibrium, became a helpless invalid. Admission to a mental hospital was necessary because the patient could not get the proper care and treatment for his sickness elsewhere.

Case V:

Mr. N. was admitted to the Boston State Hospital on September 24, 1946, and was diagnosed as having senile psychosis, paranoid type. The patient had been brought from his home by the police. The physician's certificate stated that the patient was undernourished, disoriented, deluded and hallucinated. The patient stated that he was afraid to go out doors because the mob was out there to get him. The house was barricaded against intrusion, causing the physician to have difficulty in gaining entrance. Physician stated patient was in need of care in a mental hospital. Upon admission he revealed facial paralysis as the result of a skull injury, a middle ear infection, deafness and a broken upper arm with limitations of motion in the shoulder. He was quiet and cooperative but claimed to hear voices.

The patient denied the fact that he threatened anybody with a knife. He claimed that people came into his room while he was using the bread knife

and misinterpreted the situation. He claimed to hear voices which repeated to him everything that he had said. Sometimes voices came to him from outside as if they were coming through a megaphone. The patient displayed some mild defects of memory and his ability to count and calculate was very poor. The clinical picture of this case showed that there was a psychosis probably due to clinical changes of the brain which might be arteriosclerotic or senile in nature or resulting from the recent skull injury.

The patient was born in Montreal, Canada, July 4, 1877. During his childhood he had diphtheria and in his young manhood had malaria and typhoid fever. In 1890 he came to the United States with his mother and brother. He married in 1907 and stated he had a happy married life. The patient stated that his wife died in this hospital in November, 1945, at the age of seventy-nine. They had four children; all are dead. The patient was vague as to whether they died at birth.

The patient worked as a structural iron-worker, boilermaker, and as a blacksmith's helper. At this time he was receiving Old Age Assistance.

This case is another good example of physical deterioration causing physical and mental breakdown. The clinical picture shows that the changes in the brain were because of arteriosclerotic or senile conditions common at this age level or were the outcome of his recent skull injury. Other symptoms that were manifested at this time were paralysis (complete facial paralysis) as a result of a skull injury, a middle ear infection causing deafness, and a fracture of the right humerus causing limitations of motion in the shoulder. This man was not getting adequate food to provide his body with energy and fuel so that he became undernourished.

The patient described had been in general poor physical health. He had symptoms of disorientation, delusions and hallucinations and had strange suspicions, fearing to go out doors because the mob would get him. He also claimed to hear voices.

This was a lonely old person who, because of physical and mental changes and the fact that he had had no relatives in the past few years to care for him, was now in need of hospitalization.

Case VI:

Mr. S., age eighty-one, was admitted to the Boston State Hospital on September 4, 1946, and was diagnosed as having senile psychosis, simple deterioration type. The patient was transferred under Section 51 commitment papers from the Boston City Hospital. Upon admission he was quiet and cooperative but confused and disoriented for time and place. He exhibited gross memory defects and stated that, "as a result of funny business in the state, the date had been set back twenty years last year." Therefore, he stated that he was now sixty instead of eighty years of age.

The patient was an elderly man who showed disorientation, retardation, organic mental changes, memory disturbances, emotional apathy, general feebleness and a lack of interest in general events. Physical examination revealed an aged, feeble white male whose pupils reacted sluggishly to light and who exhibited a course of tremor of extended hands and fingers.

The patient was born in New York in 1865. His mother and father were both born in the United States and had been dead for some years. He had several brothers and sisters of whom only two were alive and they were unable to care for him.

The informant was a niece who stated that the patient's parents had always been very protective and devoted to their children.

The patient was a graduate from high school. He never married. For many years he worked for the Colgate Company and later managed a music school. He had been retired for some years now.

Mr. S. always led a normal life, enjoyed other people, was always in excellent physical health, and had no previous mental illness.

In June, 1946, the patient suffered a fall while on the street. The niece questioned whether this fall might have been due to a shock. She stated that since that time he had become quiet and forgetful. He did not remember when he last ate. The patient did not recognize people and had never become violent.

This case gives a picture of a person who had always lived a normal healthy life but in whom simple deterioration has been taking place for some time. In Table VIII, page forty-three, it can be seen that fixed pupils occurred with five of the twenty-one patients studied. This person, whose pupils reacted sluggishly, was put into that category.

Although the patient was probably passing into a psychotic state very gradually, it didn't become perceptive until after the patient's accident when he fell on the street.

This patient, although not bedridden, was feeble and had ailments characteristic of old age and because of his psychotic condition needed proper care. Because he never married and his relatives were limited, his avenues for proper care at home were closed, necessitating admission to a

mental hospital.

## Environmental Maladjustments

It is the purpose of this section of the chapter to attempt to answer the question, "How does environmental maladjustment influence senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?"

The question can best be answered by showing the relationship of environmental maladjustment to psychosis in old age. By environmental maladjustment is meant that the conditions surrounding a person's everyday life are not normal according to the norms of our society.

Maladjustments of this type may occur early in life or late in life. As a person grows older, an adjustment is harder to make and psychosis is more apt to develop. However, in the cases that follow, the persons had a maladjusted environment over their entire lifetime.

Case VII:

> Mr. F., age seventy, was admitted to the Boston State Hospital on September 4, 1946, and diagnosed as having arteriosclerosis with psychosis. The patient was transferred from the Boston City Hospital with a Section 51 commitment paper stating that he was disoriented, deluded, paranoid and confused. He was heavily sedated with paraldehyd upon arrival at the hospital and moaned but said nothing that could be understood. He was uncooperative, dirty and confused, but mildly cheerful. He

indicated that he had no idea of time and place. Patient referred to enemies and became quite excited and indicated that they were after him. When asked, "Why?", he replied, "Murder!" His talk was in a hoarse whisper most of which was unintelligible.

Physical examination revealed weakness of his entire left side, questionable left Babinsky, wasting of lower extremities, and moist rales at his right lung base.

The patient, the youngest of four children, was born in Boston in 1876, having two brothers and a much older sister. The father was born and brought up in Ireland and the mother in New Brunswick, Canada. The father died of cancer when the patient was eight years old and his mother died when he was thirty-two.

The patient was a cripple from the age of two as a result of spinal paralysis. He started school at the age of six in South Boston and completed grammar school. He was fairly bright in his school work but was handicapped by his crippled leg from taking part in sports although he loved to watch them.

After the death of his father, the family life fell apart. The patient's sister worked to support the family, but after the three boys were sixteen or eighteen, they were responsible for themselves. Neither the sister nor any of the brothers ever married.

After graduation from school, the patient immediately went to work as a clerk. According to the record, the patient always had an exaggerated sense of his own ability to impress other people. He liked to be the center of group attention and craved approbation. His ambition was to become a politician. He attended the Catholic Church regularly and sang in the choir when an adult. He started drinking at the age of twenty and had been arrested many times for drunkenness. He liked to spend time with cronies in taverns and bar rooms. He listened to baseball games and fights on the radio. The patient changed jobs frequently because he thought he knew more than his bosses and became disliked because he talked

too much.

> The patient was an inmate of the Long Island Hospital for about fifteen years until he reached the age of sixty-five and then received Old Age Assistance. It was believed that he was taken to the Boston City Hospital prior to his transfer to the Boston State Hospital because of cerebral trouble.

This is a good example of environmental maladjustment which eventually led to the patient's psychosis. The patient early in life was faced with the difficult adjustment of accepting his physical handicap. His family was broken up when he was eight years of age so that the home environment was strained and he went to work after his graduation from school. The patient did not adjust to his environmental situation in his field of work and had difficulty holding positions and living with people. He had an exaggerated desire to win approval and recognition from the members of society. This he had hoped to do through politics.

The patient sought alcohol as an escape from reality and as a means to aid him gain recognition. He became increasingly insecure and unable to adjust to people or jobs, moving frequently from job to job, never accepting any given situation. His failure to succeed in any line of work left him with little means for a livelihood or the care he should have with advancing years. Since he had no relatives to care for him as his health declined and psychosis developed, hospitalization became necessary.

Case VIII:

Mr. H., age seventy, was admitted to the Boston State Hospital on September 3, 1946. He was diagnosed as being senile psychotic, probably with arteriosclerosis. The patient had previously been in the Boston City Hospital with pneumonia and from there was transferred to the Boston State Hospital. The patient was admitted because he presented peculiar religious ideas, showed a lack of moral consciousness and was an alcoholic derelict. Upon admission, he was quiet, agreeable and cooperative but discussed religious subjects in a rambling incoherent manner. He showed poor judgment and insight.

Physical examination revealed him to be a feeble, decrepit old man. He was poorly nourished, had moisture in both lungs and had a chronic cough.

The patient was born in 1876 of Irish descent but nothing was known about his parents or early family life. He had spent most of his life in Boston, leading a vagabond existence. He was very difficult to get along with and was in numerous fights over beds in cheap rooming houses. He had served innumerable jail terms for intoxication.

At one time, he was an apprentice in the iron-molding trade, but more recently a dish washer in various restaurants. Also, he had done steam-fitting and sheet iron work.

The patient never married and stated that he had no use for the opposite sex.

About eight or ten years ago he was at the Boston State Hospital for nervousness and excessive drinking. At the time he was admitted to the Boston State Hospital, he was found in a Salvation Army hotel.

This case is an example of a patient who was maladjusted in his environment and was not able to establish a good identification with any person or situation. This was probably due to the fact that he was a foreigner, born and brought up to

believe and accept different customs and cultural patterns from those of this country.

The patient presented a picture of insecurity and dual personality patterns. His inability to get along with others and his numerous fights probably indicated lack of insight or desire to cooperate with other people. His vagabond existence and the fact that he did not maintain employment in one trade but degenerated to a dish washer from a steam-fitter and iron-worker indicated maladjustment at his place of employment. The patient lacked the will to refuse gratifications of his instinct. To escape reality he resorted to the artificial mechanism of alcohol and undesirable companions. This only intensified his problems and resulted in his serving innumerable jail terms.

Here is a picture of a patient who, because of his lack of stability, is unable to adjust to his environment and, therefore, is not able to withstand any situational stresses but follows the line of least resistance. The continued lack of facing realities and seeking an easier way degenerates into a mental breakdown.

## Economic Maladjustments

It has been brought out in Chapter II that economic adjustments in an aged person can at times be maladjustments. New adjustments in old age introduce strains which the

physical and mental condition of a person cannot accept.

This section of the chapter shows evidences of economic maladjustments which contributed to senile psychosis and hospitalization in the cases under study.

In the study of these cases, an attempt is made to answer the question, "How does economic maladjustment influence senile or arteriosclerotic psychosis in persons over sixty years of age and their admission to the Boston State Hospital?"

By economic maladjustments is meant living conditions to which a person does not readily adapt himself. Usually when this happens and a state of psychosis develops, hospitalization is sought because there is either not enough room in the house for the person or there is no one to take care of him.

In the three cases given below, two are examples of senile psychosis and the third is an example of arteriosclerotic psychosis. There is actually no perceptible landmark where psychosis begins in the first case. However, in the second and third there are situational stresses which seem to be the turning points between the normal mental state and psychosis.

Case IX:

Mrs. K., age sixty-nine, was admitted to the Boston State Hospital on September 6, 1946. Her

case was diagnosed as senile psychosis, depressed and agitated types. The patient was brought to the hospital by her husband, daughter and a police officer and was admitted under Section 79.

Upon admission she was quiet, cooperative, friendly, labile and somewhat confused. Gross memory defects were noted. She could not give her address and did not know the day or the month and thought the year was 1736. She had some aphrasia and her talk was irrelevant and at times incoherent.. When at home, she had caused difficulties by running away and getting lost.

A mental examination revealed that the patient was depressed and had guilt feelings about the way she had treated her husband. Physical examination revealed a coated tongue and sclerotic radial arteries and advanced organic deterioration.

The patient was born in New Brunswick, Canada, had a grammar school education and at the age of eighteen, upon her mother's death, came to Boston. The patient was the oldest of five children. The father was a well-known wood carver and had done carvings for several public buildings in the United States. Both the mother and father loved their children and were very kind to them. The father died of a heart attack at the age of sixty.

The patient went to work for the Electric Light Company as a telephone operator and later did the same type of work with the Boston Terminal Company. She was very popular. She met Mr. K. when she was twenty-seven years old and three years later they were married. Mrs. K. was very fond of outdoor life and moving pictures. Her life with her husband was very pleasant and happy. She brought up two splendid daughters and her care was reflected in them. Her one failing was refusing to talk when cross with anyone. This might keep up for a day or two.

Both Mr. and Mrs. K. were living with their married daughter prior to her admittance to the hospital. The living quarters were small and congested. The husband lived on a small pension and Old Age Assistance.

Mr. K. made the following statement about his wife. "I have no idea what brought on the present condition. About a year ago, I took her to the doctor and he said she had heart trouble and high blood pressure. She has been taking a 'booster' three times a day and one vitamin pill. Loss of memory, inability to dress or undress herself, hiding money and jewelry (some not found yet) and an unwillingness to eat have been the most prominent features of the case. She has no idea of her daughters' names or any of her own family. At one time my wife had the care of a large single house. Perhaps this work or housekeeping contributed to her condition even though I gave her plenty of personal help."

Mrs. K. ran out of the house to neighbors on three occasions and the fourth time went out through the dining room window. She was later found by the police about a mile from home. Following this episode she was brought to the Boston State Hospital.

In the above case, the patient had lived a normal, happy life but showed emotional instability by refusing to talk for some time - a day or two - to anyone with whom she was angry. This characteristic repression probably contributed more to her eventual mental breakdown than did any physical work which she might have done.

Both Mr. and Mrs. K. were living with their daughter and were around the house most of the time. The house was hardly large enough for one extra person. Mrs. K. had gone from living in her own large home to living in a crowded place where she probably thought she and her husband were a bother and not wanted.

All these things were new economic adjustments to be made. Mrs. K. had been going through mental deterioration for

some time and when she had to adjust to her new economic status, her condition could not stand it and a depressed and agitated type of senile psychosis was hastened until it reached a point where hospitalization was necessary for her own protection and proper care. The economic situation was a factor which aggravated the final condition.

Case X:

Mr. D., age seventy-four, was admitted to the Boston State Hospital on September 3, 1946, and his case was diagnosed as one of senile psychosis, simple deterioration type. He was transferred from the Boston Psychopathic Hospital and admitted under Section 77. The patient had been transferred to the Boston Psychopathic Hospital from the House of Correction at the request of the East Boston Court. He had been charged with trespassing on another person's property before being sent to the House of Correction.

Upon admission, he was dirty and infested with vermin. He was quiet and cooperative to the admittance examination but appeared to be rather bewildered. Commitment papers stated that he was entirely out of contact, confused, disoriented and labile. Not much could be found out about his mental content because he spoke little English. A little information was gained with the help of an interpreter. His memory was greatly impaired. Also impaired were his general information and his ability to perform simple calculations. He had no insight and his judgment was very poor.

Physical examination revealed a low midline abdominal scar, a large reduciable left inguinal hernia and frequent extra cardiac systoles.

Little was known of the patient's early life. He was born in Italy of Italian parents but he was now a naturalized citizen of the United States. He evidently had little or no schooling; he could speak very little English. The only jobs ever

held were those of a laborer and he was said to be intemperate in drinking.

The patient married and had one daughter. Fourteen years ago, the daughter married her first cousin and after that the patient had nothing to do with her. He also forbade his wife to have anything to do with the daughter.

About a year and a half ago, the patient's wife died. This death greatly upset the patient and he refused to pay a $4,000 mortgage on his property. The holder of the mortgage foreclosed, but the patient refused to leave. Mr. D. then spent his days roaming the streets and eating meagerly. At night he would return to the property and sleep on the basement floor. It was because of this that the owner brought the charge of trespassing against the patient and he was taken before the District Court.

The Report of the District Court Probation Officer stated that nobody in the patient's family seemed to want him. The daughter felt that he was a mental problem as he would not take care of himself and his conversation was "irregular."

In this case as in the previous one, the patient held within himself emotional strains. This was evidenced by his having nothing to do with his daughter for fourteen years after she married her first cousin. It was also brought out that he was a domineering person because it bothered him when his daughter married against his wishes. This characteristic was also shown by his forbidding his wife to have anything to do with the daughter.

When the patient's wife died, he was left all alone. There was no one left over whom he could assert his authority and as a recourse, he refused to pay off the mortgage on his house.

The patient could not make the adjustment to living alone. The deterioration of old age had reached a point where such a situational stress could not be withstood and senile psychosis developed. His condition became worse as he ate meagerly and slept on damp basement floors. There was no one to take care of him because his children did not want him. It was, therefore, necessary for the patient to be admitted to a mental hospital.

Case XI:

Mr. Z., age seventy-seven, was admitted to the Boston State Hospital, September 11, 1946, and was diagnosed as having psychosis with organic changes to the nervous system. Symptoms were generalized as arteriosclerosis and cerebral arteriosclerosis. The patient had been transferred from the Long Island Hospital where he was described as confused, disoriented, excitable and hyperactive. He was admitted under Section 79.

Physical examination at the hospital revealed him to be feeble, arteriosclerotic with fixed pupils, hyperactive and to have deep tendon reflexes and deafness. The patient was also found to have a localized red swollen area on his left eye lid and healing superficial lacerations and abrasions of both shins. The patient was very retarded and it was hard to get in contact with him.

The patient was born in Connecticut in 1869 and was one of four children. Little was known of his early life except that he had very little education but was able to read and write. The patient never married and lived with his parents until their death some twenty years ago. At that time, he moved to Boston and has lived there ever since. The patient as a young man worked as a painter in Connecticut. At the end of that time he shifted to weaving until he lost three fingers on his right hand. It was in 1922 that he came to Boston and

worked intermittently as a painter until 1935 when he had to give up work because of a shock which caused him to fall and break his neck.

He was hospitalized at the Boston City Hospital and recovered from this illness but was never again able to work. He was later taken to Tewksbury State Infirmary and in 1940 was transferred to the Long Island Hospital. The patient stated that "he had been railroaded to the Boston State Hospital from the Long Island Hospital because the welfare department did not want to pay the pension; they wanted to have it themselves." When asked what happened at the Long Island Hospital, he replied, "They all hated me there. They wouldn't even look at me. Every time I had a bath they gave me dirty rags. The attendant there told the other inmates that I hated the Italians and the Irish like fire. That is not true. I didn't say it."

As stated in the above case, the patient had little education. Possibly with a better educational background, he would have been able to adapt himself with less difficulty to the change in his economic status after his fall.

The patient was helpless and had to depend upon the state to take care of him. The change from independence to dependence and from working to idleness presented an economic problem to which the patient could not adjust. The strain became too much and his senility and psychosis were increased.

# Chapter V

## SUMMARY AND CONCLUSIONS

The purpose of this thesis has been to make a study of the social factors influencing senile or arteriosclerotic psychosis in patients over sixty years of age and their need for admission to the Boston State Hospital. A study was made of the case records of the twenty-one patients who were admitted to the hospital during the month of September, 1946, with senile or arteriosclerotic psychoses.

The social factors influencing senile or arteriosclerotic psychosis in persons over sixty years of age and the necessity for admission to the Boston State Hospital seem to be classified in the following four groups:

1. family and marital maladjustments.
2. sickness or other physical ailments.
3. environmental maladjustments.
4. economic maladjustments.

Although the number of cases studied represented only a small group, and in some cases the records were incomplete, they showed findings similar to what other authors have found. In the findings, the social factors contributing to senile and arteriosclerotic psychoses are summarized. However, it must be pointed out that the same social factors contributing to psychosis are usually the factors contributing

to the need for hospitalization in a mental institution. These findings can be summarized as follows:

1. Family and marital maladjustments are chiefly responsible for advancing the onset of old age and causing organic deterioration, both physically and mentally. Maladjustments to such conditions as loss of loved ones, accidents to loved ones, loved ones being in danger, friction or other family or marital strife, create situational stresses and worries which tend to age a person more rapidly and cause organic deterioration in both body and mind. In some cases, the psychosis is a gradual development and it is hard to determine just when the mind passed from the normal stage to a psychotic stage. In other cases, some situational stress will be a landmark of when psychosis began.

2. Certain sicknesses are characteristic of old age and in numerous cases act as the precipitating factor which contributes to the psychosis in senile patients and the need for hospitalization. Arteriosclerosis or hardening of the arteries is the most common of the sicknesses. Others are partial paralysis, aphasia, deafness, and kidney and liver ailments. These types of ailments are usually signs of organic deterioration within the body and in cases where the physical resistance is very low, equilibrium of the mind is upset which before was maintained. Sickness can be a situational stress which will cause the mind to go from an

apparently normal state to a psychotic state. Such sickness requires constant care and makes hospitalization necessary.

3. Environmental maladjustments, such as difficulties in becoming accustomed to a new country, going through life as a cripple, having no home life and intolerance to social change, tend to strain a person both mentally and physically. Maladjustments such as those mentioned often lead to heavy drinking, improper food and an unbalanced life. These conditions will hasten the organic deterioration and the onset of senility of the individual and finally lead to mental breakdown and frequently to hospitalization. When this type of person is without friends or relatives, hospitalization in a state institution becomes necessary.

4. Economic maladjustments are caused by changes in modes of living upon reaching senility. Old people usually pass from an active state to one of retirement and from independence to dependence. Also, in some cases, they are forced to live with their children who have different ideas and habits. Often an old person loses his wife or her husband and is left alone. All these changes in modes of living are not easily adapted to by an old person who has spent the major part of his life living differently. However, in the cases where psychosis develops, deterioration has been taking place in the body for some time but the additional stress caused by an economic change is enough to swing the mind from

the apparently normal state to the psychotic state. Because of cramped living quarters or no relatives or friends to give the time to look after the individual, hospitalization becomes necessary.

It is suggested that the recognition of these four groups of factors which lead to hospitalization is essential if we are to have a more intelligent policy in dealing with senile and arteriosclerotic psychoses in persons over sixty years of age.

Approved

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# A P P E N D I X  A

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Massachusetts G. L., Ch. 123, s. 51.

Massachusetts G. L., Ch. 123, s. 79.

# A P P E N D I X B

SCHEDULE USED IN STUDY

SCHEDULE

NAME: CASE NO:
SEX: RACE: AGE: CITIZENSHIP:
OCCUPATION: DATE ADMITTED:

DIAGNOSIS:

BACKGROUND:

(1) Parental history

(2) Siblings

(3) Environment

(4) Education

(5) Marital status: Single_____Married_____Divorced_____

Separated_____Widow_____Widower_____

(6) No. of children: _____Children lived with parents____

(7) No. of times married

Reasons for other marriages or separations

(8) Other family difficulties

(9) Employment

(10) Religion Differs from wife or husband

(11) Makeup and type of personality

(12) Personal development

(13) Alcoholism and toxic influences

(14) Health history

(15) Onset of illness

(a) Symptoms

(b) Precipitating cause